

Authorization for Medication Administration by School Personnel

Student Name: _____ DOB: _____ Grade: _____

I am giving school personnel permission to administer medications to my child per the following:

Medication: _____
(one medication per form)

Non-prescription

Expiration date of medication _____

Dose (how much): _____

Prescription

Dosage to be administered at school cannot exceed manufacturer recommendation unless accompanied by a doctor's order.

Route: (circle one)

By: Mouth Ear Eye Nose Skin Inhalation
Rectal Injection

ALL MEDICATION MUST BE IN ITS NEWEST ORIGINAL CONTAINER WITH ACCURATE LABEL. Inhalers? Please have pharmacy apply a label to the canister.

Time to be given at school: _____

Reason for Medication: Check one:

- _____ Prolonged Seizure
- _____ Severe Allergic Reaction
- _____ Severe Hypoglycemic Reaction
- _____ Other (describe) _____

Special Instructions: _____

Tablets requiring cutting will be cut by the parent before being send to school. Liquid medication requires dosage spoon to be supplied by parent

Begin Date _____ **End Date*** _____

This medication needs to go on school field trips: YES _____ NO _____

- I understand I am responsible to provide this medication and maintain the supply as needed.
- I understand I am responsible to notify the school in writing of any changes.
- *Parents are required to pick up all unused medication within 10 days of dose end date. All medication left after that time will be discarded.
- Parent must notify school of any doses of OTC medications given prior to the school day to avoid overmedicating the student (i.e. if student takes a pain reliever before coming to school)
- This authorization applies only to this above listed medication and for the duration of treatment or school year.
- This also authorizes an exchange of information, as necessary, between the school nurse, appropriate school personnel and/or my child's health provider.

Parent/Guardian Signature: _____ Date: _____